BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **DAVID D. PARRISH, M.D.** Holder of License No. **26896** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-04-0018A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand, Suspension and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 9, 2005 and October 7, 2005. On February 9, 2005 David D. Parrish, M.D., ("Respondent") appeared before the Board with legal counsel Stephen Myers for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). At the conclusion of the interview the Board ordered Respondent to undergo a competency evaluation and continued the matter. On October 7, 2005 Respondent again appeared before the Board for formal interview, but was not represented by counsel. The Board voted to issue the following findings of fact, conclusions of law and order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 26896 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-04-0018A after receiving a complaint regarding Respondent's care and treatment of a 40 year-old male patient ("SG"). The complaint alleged Respondent misdiagnosed adrenal insufficiency and mismanaged

SG's medical care resulting in SG suffering from thyrotoxicosis, thrombocytopenia and cholelithiasis.

4. At the February 9, 2005 formal interview Respondent testified the applicable standard of practice was the correction of SG's sleep pattern disturbance, correction of his hormone imbalance, treatment of his chronic infections, correction of his dietary and supplementary intake, and a reduction of his stressors. Respondent testified he saw SG for only three consultations over a two month period. Respondent testified SG had the following symptoms for six or seven years: initial viral infection with following severe fatigue; marked sleep pattern disturbance; chronic myalgia; cold sensitivity and dry skin; depression impairment of short term memory and brain fog; repeated infections; reduced sexual drive and interest; irritable bowel syndrome with negative GI consults; asthmatic disorder with hoarseness; and suppressed average temperature of 97.4.

5. Respondent testified the results of two self-administered extremes and clinical materials supported a diagnosis of chronic fatigue and fibromyalgia. Respondent testified SG's yeast screen was positive in tests and at the first consultation his physical examination was negative. Respondent testified SG's blood pressure dropped, and assuming an upright stance, SG's blood pressure dropped, and SG's long history of repeated infections in inflammatory myalgia supported the impression of adrenal insufficiency. Respondent testified his clinical impression was chronic fatigue and fibromyalgia, asthma and gastric reflux per history, suppressed endocrine functions, including thyroid hypofunction, and probable yeast overgrowth of the lower GI tract. Respondent testified he gave SG the following treatment based on his clinical evaluation and lab testing: beginning on August 3, 2003 titrated T3, T4 thyroid to capture an average temperature of 98 degrees based on hypothyroid profile, suppressed temperature and rapidly deteriorating health. According to Respondent, at this point SG was hardly able to

go to work. Respondent testified that from August 17, 2003 to October 8, 2003 he gave SG replacement testosterone with an aromatic estrogen blocker to a obtain testosterone level specific for SG's age.

6. Respondent testified he gave SG fifteen milligrams of Hydrocortisone per day to be taken in divided doses with food for ten days. Respondent testified he later switched SG to two to four milligrams of dexamethasone in divided doses with food for fourteen days. Respondent testified he gave this for an elevated inflammatory index, specifically sensitive C-reactive protein, myalgia and energy reduction and unstable blood pressure. Respondent testified he gave SG Nystatin for irritable bowel and Ambien for sleep. Respondent noted as a result of this treatment when SG was last seen on October 8, 2003 all lab tests were within normal limits, an average temperature of 98.0 had been achieved, SG reported an increased energy and felt better, but also reported a URI. Respondent testified he kept all medications constant – the T3, T4 thyroid was held at sixty milligrams b.i.d. with the intention to decrease maintenance levels. Respondent noted the corticosteroid had a fourteen day limit and SG was protected from excessive levels of Cortisol by anabolic agents DHEA and testosterone. Respondent testified when SG was later hospitalized there was no clinical or lab evidence of excessive corticosteroid or testosterone nor evidence of excessive thyroid medication. Respondent testified the standard of practice for this disorder precisely followed the five designated steps.

7. Respondent testified his current practice is one where he sees chronic fatigue and fibromyalgia, endocrine modulation and some neurology and a bit of psychopharmacology. Respondent testified his training was in psychiatry and neurology. Respondent noted his neurology practice consists mostly of people with dementing disorders, the neurology and the psychiatry. Respondent testified he treated attention

deficit disorder, some partial complex seizures, but not grand mal seizures. Respondent noted he was not currently on the staff of any hospitals and had not been since he began his practice in Arizona. Respondent testified he did consultations at hospitals, but he was not on the hospital board nor a staff member. Respondent was asked how he did consultations in the hospital without being a member of the medical staff. Respondent testified he did not know, but he would be called and asked to come in and take a look at a patient. Respondent was asked which hospitals had called him to come in and look at a patient. Respondent testified it had not been a hospital who contacted him, but a physician who is seeing the patient with him after Respondent had referred the patient to them for internal medicine issues and they have asked him to come and see the patient. Respondent stated he does not put a note in the chart, but usually just communicates with the other physician or the patient's family. Respondent agreed he would describe these visits as social visits since he did not make notes in the chart, did not write orders and did not make recommendations in terms of treatment.

8. Respondent was asked to describe his continuing medical education ("CME") for the past two years. Respondent testified he had taken a number of courses in Arizona and had studied with another person for five years in chronic fatigue and fibromyalgia and with an endocrinologist. Respondent noted he also attended general medical conventions. Respondent was asked to more specifically describe the accredited CME courses he had attended. Respondent testified he took a CME course with a particular physician. Respondent was asked to describe who the physician was and what course he gave. Respondent testified the physician was regarded as one of the foremost preventative endocrinologists in the world and the average CME from him was about twenty credit hours. Respondent was asked where the course was given. Respondent testified the course was given throughout the country on a periodic basis,

but could not recall the one he went to. Respondent was again asked to identify an accredited Category I standard accepted CME course he had taken in the last twelve months. Respondent testified he believed he attended a course in San Diego, but could not recall the accrediting organization.

9. Respondent was referred to his notes of his first visit with SG that list chief complaint as "chronic fatigue syndrome, eight years duration." Respondent was asked how he substantiated that complaint. Respondent testified SG told him that and took two screens. Respondent was asked if by "screens" he was referring to questionnaires. Respondent testified he was and, in addition to that, he collected history and based on that made the diagnosis of chronic fatigue syndrome. Respondent noted SG also had fibromyalgia. Respondent was asked his differential diagnosis for SG. Respondent testified he considered SG might just be a person with a chronic viral infection, but he could not account for all the symptoms just based on that and felt SG had other associated symptoms that were due to another entity and that being a hypothalamic pituitary dysfunction. The Board interrupted Respondent and asked if SG complained of progressive fatigue and lack of endurance with exercise, slow recovery from minimal exercise, and shortness of breath, especially when lying down. Respondent testified SG had. Respondent was asked if SG's history was typical in his experience in dealing with patients with asthma. Respondent testified he did not usually take patients and try to treat them for asthma, but certainly some of SG's symptoms can be associated with asthma. Respondent noted SG's history of asthmatic problems did not seem to be sufficient to account for his other complaints.

10. Respondent was asked if when dealing with a patient with fatigue, lack of exercise tolerance and shortness of breath, especially when lying down, would asthma be the first diagnosis on his list or what other things would be part of that differential

diagnosis. Respondent testified anemia could be responsible, but he thinks the important thing to do is to look at the clinical profile and try to focus on that. Respondent noted he certainly thought a wide differential diagnosis was worth considering and it certainly went through his mind, but he tries to use screens and use the patient material. Respondent testified he only sees three or four patients a day and spends a lot of time with the patients listening to them and trying to narrow down the information they give him. Respondent testified he does not perform a complete physical examination and if a patient needs a complete physical he sends the patient to an internist. Respondent was asked if he considered congestive heart failure as a possible etiology of SG's complaints. Respondent testified he considered it a possibility, but not a probability. Respondent was asked what he did to rule out heart failure. Respondent testified SG gave a history of having fair endurance that was decreasing and he did not show signs of edema and his heart signs were fine. Respondent noted he understood from SG that he had a recent EKG.

11. Respondent was asked to confirm he diagnosed SG with hypothyroidism. Respondent testified he diagnosed SG as having a situation where he had a fairly normal T4 and a normal IGF-1, but the problem with chronic fatigue and fibromyalgia is blocking at the cellular level and unless you do other tests such as T3 free, T3 uptake and an inactive T3 that is embedded in the total T3. Respondent was asked if he considered himself a specialist in thyroid disorders. Respondent testified he considered himself well-informed. Respondent was asked how *Cecil's Textbook of Medicine*, a text Respondent agreed was a recognized authoritative text, would classify hypothyroidism. Respondent testified it would list certain symptoms in addition to lab values. Respondent testified what he was saying was that you need to look at the symptom profile and you need to look at the amount of bioactive thyroid circulating. The Board noted Respondent was

straying from the question and asked Respondent how he would differentiate primary hypothyroidism from secondary hypothyroidism. Respondent testified primary hypothyroidism would be due to a lack of the thyroid putting out T4 and secondary hypothyroidism could be due to lack of conversion of T4 to bioactive T3 and/or the uptake by cells of T3.

12. Respondent was asked if it is common accepted practice in allopathic medicine to have a patient take his temperature three times a day when hypothyroidism is suspected. Respondent testified it was becoming more and more an accepted practice. Respondent was asked on what he based his diagnosis of adrenal insufficiency. Respondent testified it was based on one 10:00 a.m. free cortisol and other things. Respondent testified he gave SG the 15 milligrams of hydrocortisone in divided doses over ten days because of energy reduction and elevated inflammatory index and myalgia. Respondent testified SG had a C-reactive protein of 4.04 that indicated an elevated inflammatory index and SG also had an unstable blood pressure. Respondent testified when SG stood up his blood pressure should stay the same, but preferably it should go up and SG's dropped when he stood up and he indicated he felt better when he was lying down. Respondent was asked the standard of care in diagnosing adrenal insufficiency. Respondent testified he thought you go ahead and try to treat some of this with small doses of hydrocortisone and see if the patient is responsive. Respondent was asked if a medical textbook would recommend a trial of glucocorticoid for a period of time to see if the patient got better as a way of diagnosing adrenal insufficiency. Respondent testified not necessarily, but what he was saying in the context of SG's overall case, where you have multiple suppressions of endocrine systems, it is an accepted practice. Respondent testified if you were dealing with just an adrenal problem you would want to do a twenty-four hour urine for total corticosteroids or a corticosyntropin test.

Respondent was asked if he did this. Respondent testified he did not because he did not feel it was a useful expenditure of money and was not indicated.

13. Respondent was asked if he was aware of any recognized authority or peer review journal in 2003 or subsequently that recommended a trial of glucocorticoids prior to doing any lab work in order to diagnose and/or treat suspected adrenal insufficiency. Respondent testified there was an article written by Jacob Teitelbaum in 2001 as well as a book he wrote on fibromyalgia and chronic fatigue. Respondent noted there was also *Safe Uses of Hydrocortisol* by Geoffrey's, Fourth Edition that was published in 2003. Respondent was asked if he was saying recognized authorities in endocrine disease would recommend treating a patient with glucocorticoid prior to any laboratory evaluation of the patient. Respondent testified what he was saying is that this is not just a case of adrenal insufficiency or something that is shading off Addison's and this is an embedded problem in the overall difficulty with chronic fatigue and fibromyalgia and the primary dysfunction of the hypothalamus where it has been desensitized and you have a cascading down of hypofunction of the endocrine system.

14. The Board asked if Respondent was describing a patient he felt had polyendocrine failure. Respondent testified he was. Respondent was asked what might be part of his differential diagnosis of polyendocrine failure, other than what he had already described. Respondent testified at the head of the list would be chronic fatigue and fibromyalgia by exclusion and certainly other things. Respondent was asked to name the other things. Respondent testified there might be Lyme disease, but he really did not know of anything that would give this type of picture. Respondent was asked if SG had headaches. Respondent testified he did not. Respondent was asked what he would think of the possibility of pituitary adenoma. Respondent testified he has scanned patient's adrenals to pick up any pituitary adenomas when he felt that there was a

marked suppression of adrenal output. Respondent was asked if he did this with SG. Respondent testified he did not because there were no other symptoms pointing in that direction. Respondent was asked whether it was the standard of care to look more broadly with a patient with polyendocrine failure, both thyroid and adrenal and hypogonadism. Respondent testified it would be, but the problem with this case was that he saw SG only for three consultations and, if SG did not improve, Respondent would start looking elsewhere. Respondent testified if he thought he needed to look elsewhere he will scan the patients and do corticosyntropin tests, twenty-four hour total corticosteroids, but they are expensive and also it is hard to get a lot of people to do the twenty-four hour urine.

15. The Board noted that SG presented to another physician in October 2003 with hypertension, tachycardia, and shortness of breath and was ultimately admitted to the hospital with a diagnosis of thyrotoxicosis. Respondent was asked if he was having SG regulate the thyroid medication based on his temperature curve. Respondent testified it was based on his temperature and lab tests. Respondent was asked which lab tests. Respondent testified he did a T3 free and SG delayed doing his lab tests for three or four weeks after that and Respondent told SG to get the lab done within a week. Respondent noted SG had a T3 of 3.4 and he usually tries to pick a mid-range of 3.4 to 3.6 and sometimes he has to increase it a little bit while still staying within the limit of the range in order to push the thyroid into the cells. The Board noted Respondent first saw SG on August 7th and then on August 14th, but the first lab was not drawn until September 24. The Board also noted Respondent testified his treatment that began in August was based on lab studies, but he did not receive the lab studies until the end of September. Respondent was asked how he could base his treatment on lab work

without having the lab work. Respondent testified he bases treatment on temperature and lab work when he can get the lab work.

16. Respondent was asked about his residency. Respondent testified he had a psychiatry residency and a neurology residency and when he was in residency they were intermingled. Respondent was asked if he was board certified. Respondent testified he was board certified and he had been a board examiner for about ten years in psychiatry with a secondary in neurology. Respondent was asked if he was board certified in family medicine or internal medicine, and if not, whether he had the qualifications to take the certification examination. Respondent testified he was not board certified in either area and did not know if he was qualified to take the examination because he did not know the requirements. Respondent testified he practiced some psychiatry and neurology and as he went along it became apparent to him that neuroendocrinology was an important aspect of getting the patient well so he decided it would be important for effective treatment to go back and have postgraduate training in endocrinology. Respondent testified he received this training over a thirteen year period by attending courses and seminars. The Board noted Respondent did not attend an organized postgraduate program.

17. Respondent was asked about his prescribing Armour thyroid when he first saw SG and if it was his standard of practice to not get a baseline thyroid test. Respondent testified he usually gets a baseline, but he felt in SG's situation because of the suppressed temperature, the scoring on the profile, and SG not being able to go to work, he felt he wanted to go ahead and start something. Respondent was asked if baseline levels were important prior to beginning medications for a presumed deficiency. Respondent testified baseline levels can be helpful, but he did not think that T, TSH, T4s are particularly helpful. Respondent was asked if his testimony was that the standard of

care in 2003 was to start a patient who he suspected to be hypothyroid on medication, up to two grains per day, without obtaining baseline values. Respondent testified it was indicated in the literature as optional. Respondent testified you want to do a baseline as soon as you can to see what it is, but he felt SG was in danger of losing his job. Respondent was asked if he was concerned that SG was on the medication since August 7 and at the end of September Respondent still did not have lab values. Respondent testified he would prefer to have the values, but he did not feel SG was likely to be overmedicated given SG's temperature. Respondent testified he asks patients to get lab values before they come in and, if they do not, he goes ahead and gets the lab values and then starts the medication.

18. Respondent was asked if he was using the steroid treatment for SG's fibromyalgia and chronic fatigue. Respondent testified he was. Respondent was asked if there are any contraindications to using steroids. Respondent testified you can give someone a small amount of hydrocortisone pretty much on an unlimited basis, perhaps five milligrams tid with food. Respondent testified according to his literature and training you can get up to thirty milligrams and not have adrenal suppression. Respondent testified SG was not tolerant of the hydrocortisone and he switched him to dexamethasone. Respondent was asked how long he would have kept SG on hydrocortisone, and at what dosages, if SG had been tolerant of it. Respondent testified he would go ahead and stop it maybe after a month or two, but he would put him on short courses and see what his response was and do some lab tests. Respondent testified often if he had a profile with myalgia and a high inflammatory index by lab test and a drop in blood pressure he can stabilize the blood pressure with some hydrocortisone without going to aldosterone and he considered aldosterone in SG's case.

19. Respondent was asked if there were other causes for SG's inflammatory index, such as a chronic infection. The Board also asked if Respondent was worried about giving steroids with a chronic infection. Respondent testified you want a sensitive C-reactive protein of less than one and if it is between one and about five there is the possibility of infection. Respondent testified in an elevated inflammatory index from some other things, if it is over ten, fifteen, twenty or twenty-five then often it is an inflammatory disorder due to an immune disorder. Respondent testified he felt SG had the possibility of a yeast override because he scored high on the Hopkins Intestinal Yeast Screen and Respondent gave him Nystatin for that, but he felt a limited dose of hydrocortisone, given SG's deterioration, was within what was appropriate and reasonable.

20. Respondent was asked if considered heart disease with SG's C-reactive being elevated and the lab sheet indicating it is one of the more commonly associated problems with heart disease and SG having symptoms that could be interpreted as cardiac in origin. Respondent testified he did not think it was helpful to SG's cardiovascular system to have an elevated C-reactive protein and it is an independent risk factor that you want to bring down, but you also want to look into it further and refer to a cardiologist for a work-up.

21. Respondent was asked if it was correct that he diagnosed adrenal insufficiency because of SG's orthostatic hypotension. Respondent said it was not and he diagnosed it because of several other things, including an inflammatory index and a history of repeated infection, so it was his impression SG had some degree of adrenal insufficiency. The Board noted SG's blood pressure was 142 over 90 with a pulse of 63 while sitting and when he stood up his pressure dropped to 133 over 90 and his pulse went from 63 to 65. Respondent was asked if SG was on a beta-blocker. Respondent testified he was not. Respondent was asked if there was a reason why SG's pulse did

not increase with his orthostatic hypotension. Respondent testified he could not explain it and noted the pulse will usually go up in compensation to give the blood more oxygenation. Respondent testified he thought one of SG's problems was that he had some autonomic dysfunction coming down from the hypothalamic pituitary axis and he thought it was interfering with SG's ability to be adaptive.

22. The Board's medical consultant clarified that four milligrams of Decadron equals 26 and one-half milligrams of prednisone. The Medical Consultant noted that Prednisone on a dose of over twenty milligrams a day for three weeks can cause adrenal insufficiency.

23. The standard of care for diagnosing adrenal insufficiency based on history and physical examination and confirmation by laboratory testing to determine the presence, type and cause begins with determining ACTH and Cortisol levels and a Cosyntropin test. Based on those results the physician should consider ordering more defining laboratory work and x-rays.

24. Respondent deviated from the standard of care because he based his diagnosis of adrenal insufficiency on historical and physical findings and failed to order and interpret the appropriate laboratory and x-ray testing to confirm the presence, type and cause of adrenal insufficiency.

25. The standard of care required Respondent to not begin to treat SG with corticosteroids without ordering and interpreting the appropriate laboratory and x-ray testing.

26. Respondent deviated from the standard of care because he began treating SG with corticosteroids without ordering and interpreting the appropriate laboratory and x-ray testing.

27. The standard of care requires a diagnosis of hypothyroidism based on clinical suspicions from the history and physical examination and confirmation by laboratory work-up including a sensitive TSH, T4 and Free T4. The standard of care provides that serum TS concentrations are almost never indicated because they have a low sensitivity in the laboratory evaluation of hypothyroidism.

28. Respondent deviated from the standard of care because he based his diagnosis of hypothyroidism on SG's basal body temperature and historical data and did not perform the appropriate testing resulting in his misdiagnosing hypothyroidism.

29. The standard of care requires treatment of hypothyroidism to be commenced after appropriate clinical findings and confirmation of a hypothyroid state based on laboratory testing.

30. Respondent deviated from the standard of care when he began SG on Armour thyroid at the end of his first visit before ordering and interpreting the appropriate laboratory tests to confirm a hypothyroid state.

31. The standard of care required Respondent to recognize on the second visit that SG's TSH was low secondary to Respondent previously placing him on Armour thyroid.

32. Respondent deviated from the standard of care when he failed to recognize SG's TSH was low secondary to Respondent's previously placing him on Armour thyroid.

33. The standard of care requires a diagnosis of testosterone deficiency to be based on clinical suspicion from history and physical examination and confirmation from appropriate interpretation of total and free serum testosterone levels.

34. Respondent deviated from the standard of care when he diagnosed testosterone deficiency in SG based on his interpretation that the value of serum

testosterone level measured on September 24, 2003 was low relative to SG's age despite the fact that the value was within the normal range on the laboratory report.

35. The standard of care required Respondent not to begin treatment of testosterone deficiency with testosterone supplementation in a patient with normal serum testosterone levels.

36. Respondent deviated from the standard of care when he treated SG with testosterone supplementation even though SG had normal serum testosterone levels.

37. The standard of care for treatment of chronic fatigue syndrome and fibromyalgia requires a combination of pharmacologic therapy and medications for symptom control, including a graded exercise program, appropriate education regarding the disorder, physical therapy, counseling, and cognitive behavior therapy. Chosen medications should be aimed at sleep restoration and pain control.

38. Respondent deviated from the standard of care because he chose to treat SG's chronic fatigue syndrome and fibromyalgia by putting SG on Armour thyroid and corticosteroids.

39. SG was subject to potential harm through the unnecessary exposure to corticosteroids, excess testosterone and Armour thyroid therapy that were not indicated based on history, physical examination and laboratory evaluations.

40. SG was harmed because his hypothyroid state was caused and aggravated by Armour thyroid and resulted in his hospitalization.

41. The Board noted that after listening to Respondent's testimony it was very concerned about his fund of knowledge and understanding of endocrine disease. The Board noted it was uncertain about Respondent's knowledge of pharmacology, his knowledge of differential diagnoses, even his ability to formulate some very basic differential diagnoses in the area of endocrine disease in a way that meets the standard

of care. Based on these concerns the Board issued an Interim Order requiring Respondent to undergo an evaluation at the Physician Assessment and Clinical Education ("PACE) program in San Diego, California, to give the Board a more comprehensive look at his fund of knowledge, especially in the areas of his current practice. The Board entered findings relating to unprofessional conduct and continued the interview indicating it would determine the appropriate sanction and any other necessary action after reviewing the PACE evaluation.

42. The Interim Order was mailed to Respondent on February 16, 2005 and required Respondent to complete the evaluation within ninety days. An Interim Order issued by the Board is not an appealable agency action. A.R.S. § 41-1092(3). Respondent was required to complete the evaluation by May 23, 2005. Along with the Interim Order the Board's Compliance Staff sent Respondent information regarding PACE and forms to sign and return to Board Staff by March 3, 2005 indicating he understood the requirements of the Order. Board Staff contacted Respondent on March 4, 2005 inquiring about the status of the forms. Respondent stated he was out of town for three weeks and would return them as soon as possible. Board Staff received the signed forms on March 7, 2005.

43. On March 8, 2005 Respondent contacted Board Staff and asked for an extension to complete the PACE evaluation since he was out of town for three weeks. Board Staff informed him that the Board had set the applicable time-frame at the meeting and he was required to complete the evaluation by the designated May 2005 date. Respondent was told he needed to complete the evaluation or he would be in violation of a Board Order. On April 29, 2005 Board Staff contacted PACE and was told Respondent had not contacted PACE to schedule his evaluation. Board Staff sent Respondent and his attorney a letter requesting they contact Board Staff as soon as possible.

Respondent called Board Staff on May 10, 2005 reporting he had not submitted to the evaluation.

44. At the October 7, 2005 formal interview Respondent testified he provided the Board with more than sufficient evidence to show there should be no question whatsoever regarding his activities related to SG. Respondent testified he included in the supporting material allopathic peer reviews from some of the most respected physicians in the field. Respondent testified acknowledged experts in treatment of chronic fatigue syndrome without fail have reiterated Respondent used the highest standards of practice. Respondent stated at no time did his evidence-based treatment place SG at risk. Respondent noted the physician who treated SG in the hospital has no specific knowledge of the treatment of chronic fatigue syndrome and the consulting pulmonologist disagreed with the admitting physician's assessment.

45. Respondent acknowledged the Board's responsibilities to the public and regretted his communications to the Board have proved inadequate. Respondent testified he was under the impression that his continued communication with the Board was grounds for continuing the examination of his case, which in his mind was clearly baseless for the recommendation for the PACE evaluation, in that the Board's Order would be stayed until the final adjudication of his competence in this case was handled. Respondent testified he has been advised by new counsel that an immediate motion for rehearing should have been filed and he now stands in violation of the Board's Order.[1] Respondent testified it was not his intention to violate the Order and he did not question the Board's authority nor did he wish to violate its trust.

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[1] As noted, the Board's Interim Order was not an appealable agency action and was similarly not subject to a motion for rehearing.

46. Respondent testified he investigated the PACE evaluation and the cost was very high and he was told the evaluation was not appropriate for him. Respondent testified in either case he accepted the responsibility for the miscommunication. Respondent stated he tried to supply the Board with more than adequate grounds for dismissal because the public deserves to be protected by doctors who remain current and he is such a doctor. Respondent testified it would be a disservice to him and the public to punish him for maintaining the highest standards of his profession.

47. Respondent was asked if he understood the Board issued an Interim Order dated February 16, 2005 requiring him to undergo a PACE evaluation. Respondent testified he would respond by reiterating he accepts the responsibility for not following the Board's Order and stated he was misled by counsel and believed while the Board's review of his case was an on-going process he did not have to attend PACE. Respondent was asked if he was advised by Board Staff on several occasions that he was required to complete the evaluation by a certain date. Respondent testified he would only respond by his previous comment and he repeated that comment. Respondent was asked if despite reminders near the end of the ninety days he still did not feel the Board had the authority to order the evaluation. Respondent testified he would only reiterate what he had just said.

48. It is necessary for this decision to take immediate effect to protect the public health and safety and a rehearing or review is contrary to the public interest. A.A.C. R4-16-102(B).

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public;") 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient;") and 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Letter of Reprimand for misdiagnosis and mismanagement of thyroid disease.

2. Respondent is Suspended and placed on Probation for one year with the following terms and conditions:

a. Within 90 days Respondent shall, at his own expense, undergo a PACE evaluation. Any and all reports, assessments or other documents generated by PACE shall be forwarded by PACE to the Board for review. The suspension will not terminate prior to the Board's review of the PACE evaluation. The Board may initiate a new action based on the results of the PACE evaluation.

b. In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and

return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence of practice outside Arizona or of non-practice within Arizona will not apply to the reduction of the probationary period.

c. Respondent shall obey all federal, state, and local laws and all rules governing the practice of medicine in Arizona.

d. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all conditions of probation. The declarations shall be submitted on or before the 15th of March, June, September and December of each year, beginning on or before March 2006.

RIGHT TO APPEAL TO SUPERIOR COURT

Respondent is hereby notified that this Order is the final administrative decision of the Board and that Respondent has exhausted his administrative remedies. Respondent is advised that an appeal to Superior Court in Maricopa County may be taken from this decision pursuant to Title 12, Chapter 7, Article 6.

DATED this 12th day of December, 2005.

ARIZONA MEDICAL BOARD 1913 STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By_____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 12th day of December, 2005 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Certified Mail this
12th day of December, 2005, to:

David D. Parrish
Address of Record

Lisa McGraw